Supreme Court, U.S.
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No. 99-249

IN THE
Supreme Court of the United States

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA,

Petitioner,

v.

UNIBELL ANESTHESIA, P.C.,

Respondent.

ON PETITION FOR A WRT OF CERTIORARI TO THE SUPREME COURT OF THE STATE OF NEW YORK, APPELLATE DIVISION, FRST DEPARTMENT

REPLY BRIEF FOR PETITIONER

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FURTHER REASONS FOR GRANTING THE WRIT

I.

RESPONDENT'S BRIEF CONTAINS NUMEROUS MISSTATEMENTS.

Respondent makes numerous factual errors in its brief. Several are particularly relevant to the petition.

On page 2 respondent presents three contentions implying that these were the discrete issues submitted to the jury. The record, however, indicates that ERISA related "incurred claims" issues were central to the charge and inextricably intertwined with Unibell's claims. (1188-1198).[1] There were no independent state law theories of recovery. The Medicare allegations were incorporated into the ERISA theory, with an instruction to the jury that Unibell claims that Guardian should have disclosed the Medicare status of Greta Filler "to avoid making a disclosure of the incurred claims figures not misleading" (1189).

The allegations in paragraph (iii) on page 2 of the respondent's brief concerning the broker were not proven at trial and were not submitted to the jury.

On page 3, and at several points thereafter, respondent states that Guardian took two appeals below to the intermediate Appellate Division. One appeal concerned the pretrial motion for summary judgment. The second was the subject appeal. Respondent states (*e.g.*, on page 3) that Guardian did not present appellate ERISA issues until the second appeal, implying that this issue was untimely. The contention is also made on page 3 that ERISA preemption was not raised until the case had been litigated for "more than two years."

Despite Unibell's suggestions to the contrary, the ERISA preemption issue was raised in a timely fashion. Guardian moved for summary judgment on the state law based causes of action alleged in the original amended complaint. Only state law issues were presented. The denial of this motion was appealed to the

1. References are to the pages of the record on appeal to the New York Supreme Court, Appellate Division, First Department.

Appellate Division, which affirmed. 239 App. Div. 2d 248 (1st Dept. 1997). The appeal was concluded months before Unibell sought to amend its complaint to inject the ERISA-related "incurred claims" issue.

During that appeal respondent *for the first time* briefly raised the then unpleaded arguments concerning the incurred claims renewal letter issues. Under New York law unpleaded matters may be raised as a defense to a motion for summary judgment. *See, e.g., Denburg v. Parker Chapin Flattau & Klimpl*, 213 A.D.2d 297 (1st Dept. 1995). Guardian could not object to such submissions under state law.

It is an entirely different issue whether the action could have been removed during the first appeal based upon a mere reference to an issue in a brief. With limited exceptions removal issues must be raised in pleadings. *See Crump v. Wal-Mart Group Health Plan*, 925 F. Supp. 1214, 1217-19 (W.D. Ky. 1996), where the court rejected the argument that the time for removal commenced when federal issues were raised on a state court motion. Instead, the time for removal was found to run from the amendment of the complaint.

Under state law, an amendment to the complaint was required to raise affirmatively these new charges. Respondent delayed moving to amend until the time of trial, and the motion was granted moments before the trial actually commenced (10). The new allegations were that the claims reported in the 1991 renewal proposal included claims for medical services rendered during years before the period specified in the letter. It was also contended that claims were double-counted — *i.e.*, for the year the services were rendered and for the year paid by Guardian (60a). Intentional misrepresentation of ERISA fiduciary payments was alleged. Guardian immediately sought removal. Any earlier attempt to remove based upon the mention of such matters in respondent's brief submitted on appeal from the denial of summary judgment would have been sanctionable.

The argument of respondent on pages 21-22 that ERISA *subject matter jurisdiction* preemption claims are waived by

untimely assertion is completely erroneous in any event. The cases cited by respondent involved ERISA benefit claims which may be brought either in federal or state court. *See Wolf v. Reliance Standard Life Ins. Co.*, 71 F.3d 444 (1st Cir. 1995), relied upon in the district court case cited by respondent on page 22, where the distinction between such cases and "nonwaivable" subject matter jurisdiction issues was emphasized. "Our holding is limited to ERISA preemption of benefits — due actions. ERISA permits several other types of civil actions (e.g. for injunctive relief, for breach of fiduciary duty, etc.) subject to exclusive jurisdiction in the federal courts rather than concurrent jurisdiction." *Id.* at 449, n.8. Jurisdiction over ERISA fiduciary breach claims lies exclusively with the federal courts. 29 U.S.C. § 1132(e).

On page 6, respondent presents irrelevant factual contentions concerning Medicare related issues. It is submitted that focus should not be diverted to such factual issues. These matters can be addressed in a federal district court trial where the claims of ERISA fiduciary breach should be resolved. At such a trial Guardian will establish that the causes of action which could be asserted under ERISA have no merit. These matters, however, are completely irrelevant to the jurisdictional issues presented in the petition.

II.

THE SUPREME COURT SHOULD REVIEW THE RULE OF LAW DECLARED BY THE STATE COURTS.

Respondent candidly admits that the state courts held that they had jurisdiction to determine an action seeking damages based upon allegations that, during the renewal of a plan, an ERISA fiduciary misrepresented acts performed in a fiduciary capacity. *See* page 18 of the respondent's brief where this result is sought to be upheld by a mistaken reading of the ERISA "relate to" concept — a reading which is completely at odds with *Varity Corp. v. Howe*, 516 U.S. 489 (1996), discussed in the petition. As discussed at page 11 of the petition, acts relate to an ERISA plan, and are preempted from being the subject of

a state court suit if state regulation of such matters would impede the nationally uniform administration of ERISA plans. *Indeed, on page 18 of its brief respondent concedes that the claims information set forth in the 1991 renewal letter "refer[s] to acts performed in a fiduciary capacity." See also* page 8 of the respondent's brief where it is contended that the Guardian underwriters deliberately provided erroneous claims data "to persuade Unibell to renew" the plan.

On page 20 respondent acknowledges that *Varity* held that supplying ERISA plan related information to persuade persons or entities to remain in a plan is an act of plan administration, implicating fiduciary obligations. The rule cannot be otherwise where, as here, such allegedly false information is provided by an ERISA insurer/fiduciary during the renewal of a plan. The rule would presumably apply during the regular renewal of insurer issued ERISA plans. An ERISA insurer is entitled to the benefit and protection of a trial of such allegations in the proper forum where state tort law passions are absent. The greater burdens imposed upon ERISA fiduciaries by federal law requires a proper forum for the resolution of disputes between ERISA entities. Allegations constituting charges of ERISA fiduciary breach should not be decided in a typical state court tort jury environment.

On pages 20-21 respondent argues that the federal courts have not imposed a blanket rule that state law resolution of all ERISA plan renewal claims is preempted. This, however, is not the rule advanced by petitioner. Petitioner instead urges this Court to adopt a rule that any claim that an ERISA fiduciary deliberately provided false plan related information to seek to induce renewal is so related to plan administration under *Varity* that the federal courts must determine the law under which such actions are to be resolved. The affirmed finding of the trial court on the post trial motion that ERISA plan renewal fraud claims are not preempted, discussed at page 13 of the respondent's brief, should be set aside by this Court.

Respondent makes several misstatements concerning *Varity*. On page 19 respondent claims that *Varity* was not a preemption case. However, the issue addressed in *Varity* was whether federal jurisdiction existed under ERISA to remain in that venue. This is the same question presented in a preemption defense raised in state court. *See Farr v. U.S. West Communications, Inc.*, 151 F.3d 908, 913 (9th Cir. 1998), where *Varity* was relied upon in the court's preemption analysis.

In *Varity* this Court rejected arguments that providing information not required by ERISA's disclosure rules, to seek to induce renewal, precluded a finding of plan administration. *Varity*, 516 U.S. at 504. Consequently, the trial court's finding in the present action that preemption is precluded because ERISA did not require the inclusion of claims data in a renewal proposal is in direct conflict with *Varity*. *See* page 24 of respondent's brief for discussion of trial court's finding. Equally erroneous under *Varity* is the post-trial finding, discussed on page 13 of the respondent's brief, that the claims representations were unrelated to Guardian's ERISA fiduciary status. Unless this decision is reversed, Guardian will remain subject to suit in New York state courts for allegedly inaccurate reporting of ERISA claims payments in renewal proposals. At least 25% of the claims paid annually by Guardian are for medical services rendered during earlier policy years (826-27).

The argument of respondent on page 17 that a party can avoid ERISA preemption by pleading only state law causes of action concerning ERISA plan related activities is erroneous. Where there is complete federal preemption of a specific area of the law, any complaint purporting to raise a state law claim in such area is preempted. The "well pleaded complaint rule" does not apply under such circumstances. *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66-67 (1987), where it was held that causes of action pleaded under state law seeking to enforce what were, in reality, ERISA claims were "necessarily federal in character by virtue of the clearly manifested intent of Congress" and were removable by the defendant. *See also Smith*

v. Provident Bank, 170 F.3d 609, 613-14 (6th Cir. 1999), applying this rule to a state law claim of breach of ERISA fiduciary duty.

The respondent states on pp. 26-27 that the "Appellate Division expressly recognized in its order that Unibell had charged Guardian with wrongdoing in its capacity as a seller of insurance, not as a claims fiduciary, and that ERISA's preemption clause did not apply." This is a candid admission that the state court failed to apply the well pleaded complaint rule discussed at page 24 of Guardian's brief to that court. There can be no exception to this rule, as implicitly urged by respondent, simply because the alleged breach occurred during the renewal of an ERISA plan. Federal law, not state pleading rules, must determine this case.

III.

THE SUPREME COURT SHOULD DECLARE THAT ACTIONS AGAINST AN ERISA FIDUCIARY REQUIRING AN INTERPRETATION OF THE TERMS OF AN ERISA PLAN CANNOT BE MAINTAINED IN THE STATE COURTS.

As discussed in the petition, respondent contended at trial that Guardian deceived it by using the term "incurred claims" in the 1991 renewal letter. This is not disputed by respondent. *See, e.g.*, pages 22-23 of the respondent's brief, where it is stated that Dr. Herman Turndorf, the president of Unibell, "understood Guardian to be describing the cost of the care that was provided to Unibell employees during the time period referenced in the letter." It is further argued on page 23 that "Unibell's expert confirmed that Dr. Turndorf's understanding was in fact the common understanding in the industry." Respondent also asserts on page 23 that a Guardian's witness also used the term in the sense understood by Dr. Turndorf.

It is submitted that, at this point, the relevant issue is not whether Guardian did in fact intentionally mislead respondent in the renewal letter. This is another factual question that can be addressed in a federal action. The issue of importance is the

threshold question of whether a state court has jurisdiction over a tort action which must involve an analysis of an ERISA plan. Reference to the ERISA plan was necessary in order to determine whether, as contended by Guardian, the term "incurred claims" was correctly used. *See, e.g.*, pages 825-26 of the record, where a Guardian officer referred to the policy to defend the use of "incurred claims" in the 1991 renewal letter. When Dr. Turndorf and the respondent's expert confused the concepts of a medical charge and a claim, they were describing a situation in conflict with the ERISA plan. Most importantly, the issue should be addressed whether ERISA can allow a rule of law which would permit suits for fraud or other state torts in state court based upon an interpretation of plan terminology. It is submitted that the meaning of ERISA plan provisions must be determined pursuant to the federal common law. Whether an ERISA fiduciary used plan related terminology to deliberately deceive one owed a fiduciary obligation must be a federal question. As stated in *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 213-14 (1985), discussed on pages 16-17 of the petition, that the issue of whether a state tort "is sufficiently independent of federal contract interpretation to avoid preemption, is, of course, a question of federal law." Respondent ignores this rule's obvious application to this action.

It is disingenuous for respondent to argue on page 17 that it never challenged any determination made by Guardian, as an ERISA fiduciary, to pay the two N.Y.U. claims. Respondent also states on page 17 that it never questioned the consistency between the policy terms and the 1991 renewal letter. Both of these contentions ignore the obvious interrelationship between the policy provisions concerning when a claim or a charge is incurred, (petition, page 4) and the respondent's contention that these terms had legally cognizable meanings unrelated to the ERISA plan.

Guardian's contention that preemption flows from the need to interpret the plan is not a new argument, as claimed by respondent on page 22 of its brief. Guardian has argued

consistently since the day the trial commenced, when the incurred claims allegations were added, that ERISA preemption applied for the reasons discussed in this point. *See, e.g.*, page 26 of Guardian's brief to the Appellate Division discussing the preemptive effect of the fact that the Unibell claims cannot be evaluated without a reference to the plan. Point II(c) of Guardian's brief in support of the motion for leave to appeal to the state Court of Appeals was captioned "The Incurred Claims Allegations Of Unibell Cannot Be Evaluated Without Reference To The ERISA Plan And Are Consequently Preempted."

In addition, this argument would be proper in support of the petition in any event since ERISA preemption had been raised below. It is not disputed that this issue predominated at the trial and on appeal. "Once a federal claim is properly presented, a party can make any argument in support of that claim; parties are not limited to the precise arguments they made below." *Yee v. City of Escondido*, 503 U.S. 519, 534 (1992). There is no basis under applicable law for respondent to raise a "new argument" contention under these circumstances.

IV.

THE STATE COURT AND RESPONDENT MISAPPLY ERISA'S "SAVINGS CLAUSE".

As shown on pages 20 *et seq.* of the petition, the Appellate Division misapplied the ERISA "savings clause" to avoid preemption of respondent's common law and statutory causes of action. On page 26 of its brief, respondent claims that the state court did not apply the "savings clause," but rather adopted that part of respondent's brief which argued that ERISA preemption is "inappropriate in matters not directly related to plan administration or participant claims for benefits, particularly where a strong state interest is present, such as the state interest in regulation of the insurance industry." Respondent acknowledges on page 26 that the two cases cited by the Appellate Division in its decision were also cited by respondent in its brief as authority for the quoted statement.

It is quite apparent that the quotation above is a description of the circumstances under which the ERISA "savings clause" has been applied by this Court. *See, e.g., John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99-100 (1993), cited by respondent and by the Appellate Division, where this Court declared that, while ERISA generally preempts all state laws which "relate to" ERISA plans, "[s]tate law governing insurance generally is not displaced" unless that law "stands as an obstacle to the accomplishment of the full purposes and objectives of Congress . . ." (citations omitted). In cases of direct conflict ERISA prevails pursuant to the Supremacy Clause. *Id.* at 100. Respondent's argument is simply another way of stating the principle, codified in the "savings clause," that ERISA does not preempt state insurance laws which regulate insurance unless such laws directly conflict with ERISA.

In reality, therefore, respondent made a "savings clause" argument, without attaching that label, and the state court accepted this argument as the basis for its rejection of Guardian's preemption arguments! Yet, for the reasons discussed in the petition, the "savings clause" was inapplicable to this case.

Nowhere in its brief does respondent dispute the fact that all of the state common law and statutory causes of action upon which it recovered fell outside of the absolute requirement that the "savings clause" only applies to state laws directed to the insurance industry. Respondent's attempt to distinguish this case from *DeBruyne v. Equitable Life Assurance Society*, 920 F.2d 457 (7th Cir. 1990), discussed at pages 21-22 of the petition, must fail. Any factual differences are irrelevant since respondent does not dispute that § 4226 of the Insurance Law, at issue here and in *DeBruyne*, is simply the codification in an insurance statute of what would otherwise be an applicable general rule of New York common law. Such statutes are not protected from preemption by the "savings clause." *Unum Life Ins. Co. of America v. Ward*, __ U.S. __, 119 S. Ct. 1380 (1999). See page 21 of the petition.

CONCLUSION

The petition should be granted.

Respectfully submitted,

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